

rectly resulting from the reduction in payment amounts under sections 1395w-4(a)(7), 1395w-23(l)(4), 1395w-23(m)(4), and 1395ww(b)(3)(B)(ix) of this title.

(2) Payment from Trust Funds

The amount specified under paragraph (1) shall be available to the Fund, as expenditures are made from the Fund, from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund in such proportion as the Secretary determines appropriate.

(3) Funding limitation

Amounts in the Fund shall be available in advance of appropriations but only if the total amount obligated from the Fund does not exceed the amount available to the Fund under paragraph (1). The Secretary may obligate funds from the Fund only if the Secretary determines (and the Chief Actuary of the Centers for Medicare & Medicaid Services and the appropriate budget officer certify) that there are available in the Fund sufficient amounts to cover all such obligations incurred consistent with the previous sentence.

(4) No effect on payments in subsequent years

In the case that expenditures from the Fund are applied to, or otherwise affect, a payment rate for an item or service under this subchapter for a year, the payment rate for such item or service shall be computed for a subsequent year as if such application or effect had never occurred.

(Aug. 14, 1935, ch. 531, title XVIII, § 1898, as added Pub. L. 110-252, title VII, § 7002(a), June 30, 2008, 122 Stat. 2394; amended Pub. L. 110-275, title I, § 188(a)(2)(B), July 15, 2008, 122 Stat. 2589; Pub. L. 110-379, § 6, Oct. 8, 2008, 122 Stat. 4079; Pub. L. 111-5, div. B, title IV, § 4103(b), Feb. 17, 2009, 123 Stat. 487; Pub. L. 111-118, div. B, § 1011(b), Dec. 19, 2009, 123 Stat. 3474; Pub. L. 111-148, title III, § 3112, Mar. 23, 2010, 124 Stat. 421; Pub. L. 111-309, title II, § 207, Dec. 15, 2010, 124 Stat. 3291.)

REFERENCES IN TEXT

Parts A and B, referred to in subsec. (a), are classified to section 1395c et seq. and section 1395j et seq., respectively, of this title.

AMENDMENTS

2010—Subsec. (b)(1)(A). Pub. L. 111-148, which directed substitution of “\$0” for “\$22,290,000,000”, was executed by making the substitution for “\$20,740,000,000” to reflect the probable intent of Congress and the intervening amendment by Pub. L. 111-118, § 1011(b)(1)(A). See 2009 Amendment note below.

Subsec. (b)(1)(B). Pub. L. 111-309 substituted “\$275,000,000” for “\$550,000,000”.

2009—Subsec. (a). Pub. L. 111-5, § 4103(b)(1), inserted “medicare” before “fee-for-service program under” and “including, but not limited to, an increase in the conversion factor under section 1395w-4(d) of this title to address, in whole or in part, any projected shortfall in the conversion factor for 2014 relative to the conversion factor for 2008 and adjustments to payments for items and services furnished by providers of services and suppliers under such original medicare fee-for-service program” before period at end.

Subsec. (b)(1). Pub. L. 111-5, § 4103(b)(2)(A), substituted “during—” for “during fiscal year 2014, \$2,290,000,000 and, in addition for services furnished dur-

ing fiscal years 2014 through 2017, \$19,900,000,000.” and added subpars. (A) and (B).

Subsec. (b)(1)(A). Pub. L. 111-118, § 1011(b)(1)(A), substituted “\$20,740,000,000” for “\$22,290,000,000”.

Subsec. (b)(1)(B), (C). Pub. L. 111-118, § 1011(b)(1)(B)–(3), added subpar. (B) and redesignated former subpar. (B) as (C).

Subsec. (b)(4). Pub. L. 111-5, § 4103(b)(2)(B), added par. (4).

2008—Subsec. (b)(1). Pub. L. 110-379 substituted “\$2,290,000,000” for “\$2,220,000,000”.

Pub. L. 110-275 inserted “and, in addition for services furnished during fiscal years 2014 through 2017, \$19,900,000,000” before period at end.

§ 1395jii. Shared savings program

(a) Establishment

(1)¹ In general

Not later than January 1, 2012, the Secretary shall establish a shared savings program (in this section referred to as the “program”) that promotes accountability for a patient population and coordinates items and services under parts A and B, and encourages investment in infrastructure and redesigned care processes for high quality and efficient service delivery. Under such program—

(A) groups of providers of services and suppliers meeting criteria specified by the Secretary may work together to manage and coordinate care for Medicare fee-for-service beneficiaries through an accountable care organization (referred to in this section as an “ACO”); and

(B) ACOs that meet quality performance standards established by the Secretary are eligible to receive payments for shared savings under subsection (d)(2).

(b) Eligible ACOs

(1) In general

Subject to the succeeding provisions of this subsection, as determined appropriate by the Secretary, the following groups of providers of services and suppliers which have established a mechanism for shared governance are eligible to participate as ACOs under the program under this section:

(A) ACO professionals in group practice arrangements.

(B) Networks of individual practices of ACO professionals.

(C) Partnerships or joint venture arrangements between hospitals and ACO professionals.

(D) Hospitals employing ACO professionals.

(E) Such other groups of providers of services and suppliers as the Secretary determines appropriate.

(2) Requirements

An ACO shall meet the following requirements:

(A) The ACO shall be willing to become accountable for the quality, cost, and overall care of the Medicare fee-for-service beneficiaries assigned to it.

(B) The ACO shall enter into an agreement with the Secretary to participate in the pro-

¹ So in original. No par. (2) has been enacted.

gram for not less than a 3-year period (referred to in this section as the “agreement period”).

(C) The ACO shall have a formal legal structure that would allow the organization to receive and distribute payments for shared savings under subsection (d)(2) to participating providers of services and suppliers.

(D) The ACO shall include primary care ACO professionals that are sufficient for the number of Medicare fee-for-service beneficiaries assigned to the ACO under subsection (c). At a minimum, the ACO shall have at least 5,000 such beneficiaries assigned to it under subsection (c) in order to be eligible to participate in the ACO program.

(E) The ACO shall provide the Secretary with such information regarding ACO professionals participating in the ACO as the Secretary determines necessary to support the assignment of Medicare fee-for-service beneficiaries to an ACO, the implementation of quality and other reporting requirements under paragraph (3), and the determination of payments for shared savings under subsection (d)(2).

(F) The ACO shall have in place a leadership and management structure that includes clinical and administrative systems.

(G) The ACO shall define processes to promote evidence-based medicine and patient engagement, report on quality and cost measures, and coordinate care, such as through the use of telehealth, remote patient monitoring, and other such enabling technologies.

(H) The ACO shall demonstrate to the Secretary that it meets patient-centeredness criteria specified by the Secretary, such as the use of patient and caregiver assessments or the use of individualized care plans.

(3) Quality and other reporting requirements

(A) In general

The Secretary shall determine appropriate measures to assess the quality of care furnished by the ACO, such as measures of—

- (i) clinical processes and outcomes;
- (ii) patient and, where practicable, caregiver experience of care; and
- (iii) utilization (such as rates of hospital admissions for ambulatory care sensitive conditions).

(B) Reporting requirements

An ACO shall submit data in a form and manner specified by the Secretary on measures the Secretary determines necessary for the ACO to report in order to evaluate the quality of care furnished by the ACO. Such data may include care transitions across health care settings, including hospital discharge planning and post-hospital discharge follow-up by ACO professionals, as the Secretary determines appropriate.

(C) Quality performance standards

The Secretary shall establish quality performance standards to assess the quality of care furnished by ACOs. The Secretary shall

seek to improve the quality of care furnished by ACOs over time by specifying higher standards, new measures, or both for purposes of assessing such quality of care.

(D) Other reporting requirements

The Secretary may, as the Secretary determines appropriate, incorporate reporting requirements and incentive payments related to the physician quality reporting initiative (PQRI) under section 1395w-4 of this title, including such requirements and such payments related to electronic prescribing, electronic health records, and other similar initiatives under section 1395w-4 of this title, and may use alternative criteria than would otherwise apply under such section for determining whether to make such payments. The incentive payments described in the preceding sentence shall not be taken into consideration when calculating any payments otherwise made under subsection (d).

(4) No duplication in participation in shared savings programs

A provider of services or supplier that participates in any of the following shall not be eligible to participate in an ACO under this section:

(A) A model tested or expanded under section 1315a of this title that involves shared savings under this subchapter, or any other program or demonstration project that involves such shared savings.

(B) The independence at home medical practice pilot program under section 1395cc-5 of this title.

(c) Assignment of Medicare fee-for-service beneficiaries to ACOs

The Secretary shall determine an appropriate method to assign Medicare fee-for-service beneficiaries to an ACO based on their utilization of primary care services provided under this subchapter by an ACO professional described in subsection (h)(1)(A).

(d) Payments and treatment of savings

(1) Payments

(A) In general

Under the program, subject to paragraph (3), payments shall continue to be made to providers of services and suppliers participating in an ACO under the original Medicare fee-for-service program under parts A and B in the same manner as they would otherwise be made except that a participating ACO is eligible to receive payment for shared savings under paragraph (2) if—

- (i) the ACO meets quality performance standards established by the Secretary under subsection (b)(3); and
- (ii) the ACO meets the requirement under subparagraph (B)(i).

(B) Savings requirement and benchmark

(i) Determining savings

In each year of the agreement period, an ACO shall be eligible to receive payment for shared savings under paragraph (2) only if the estimated average per capita Medi-

care expenditures under the ACO for Medicare fee-for-service beneficiaries for parts A and B services, adjusted for beneficiary characteristics, is at least the percent specified by the Secretary below the applicable benchmark under clause (ii). The Secretary shall determine the appropriate percent described in the preceding sentence to account for normal variation in expenditures under this subchapter, based upon the number of Medicare fee-for-service beneficiaries assigned to an ACO.

(ii) Establish and update benchmark

The Secretary shall estimate a benchmark for each agreement period for each ACO using the most recent available 3 years of per-beneficiary expenditures for parts A and B services for Medicare fee-for-service beneficiaries assigned to the ACO. Such benchmark shall be adjusted for beneficiary characteristics and such other factors as the Secretary determines appropriate and updated by the projected absolute amount of growth in national per capita expenditures for parts A and B services under the original Medicare fee-for-service program, as estimated by the Secretary. Such benchmark shall be reset at the start of each agreement period.

(2) Payments for shared savings

Subject to performance with respect to the quality performance standards established by the Secretary under subsection (b)(3), if an ACO meets the requirements under paragraph (1), a percent (as determined appropriate by the Secretary) of the difference between such estimated average per capita Medicare expenditures in a year, adjusted for beneficiary characteristics, under the ACO and such benchmark for the ACO may be paid to the ACO as shared savings and the remainder of such difference shall be retained by the program under this subchapter. The Secretary shall establish limits on the total amount of shared savings that may be paid to an ACO under this paragraph.

(3) Monitoring avoidance of at-risk patients

If the Secretary determines that an ACO has taken steps to avoid patients at risk in order to reduce the likelihood of increasing costs to the ACO the Secretary may impose an appropriate sanction on the ACO, including termination from the program.

(4) Termination

The Secretary may terminate an agreement with an ACO if it does not meet the quality performance standards established by the Secretary under subsection (b)(3).

(e) Administration

Chapter 35 of title 44 shall not apply to the program.

(f) Waiver authority

The Secretary may waive such requirements of sections 1320a-7a and 1320a-7b of this title and this subchapter as may be necessary to carry out the provisions of this section.

(g) Limitations on review

There shall be no administrative or judicial review under section 1395ff of this title, section 1395oo of this title, or otherwise of—

(1) the specification of criteria under subsection (a)(1)(B);

(2) the assessment of the quality of care furnished by an ACO and the establishment of performance standards under subsection (b)(3);

(3) the assignment of Medicare fee-for-service beneficiaries to an ACO under subsection (c);

(4) the determination of whether an ACO is eligible for shared savings under subsection (d)(2) and the amount of such shared savings, including the determination of the estimated average per capita Medicare expenditures under the ACO for Medicare fee-for-service beneficiaries assigned to the ACO and the average benchmark for the ACO under subsection (d)(1)(B);

(5) the percent of shared savings specified by the Secretary under subsection (d)(2) and any limit on the total amount of shared savings established by the Secretary under such subsection; and

(6) the termination of an ACO under subsection (d)(4).

(h) Definitions

In this section:

(1) ACO professional

The term “ACO professional” means—

(A) a physician (as defined in section 1395x(r)(1) of this title); and

(B) a practitioner described in section 1395u(b)(18)(C)(i) of this title.

(2) Hospital

The term “hospital” means a subsection (d) hospital (as defined in section 1395ww(d)(1)(B) of this title).

(3) Medicare fee-for-service beneficiary

The term “Medicare fee-for-service beneficiary” means an individual who is enrolled in the original Medicare fee-for-service program under parts A and B and is not enrolled in an MA plan under part C, an eligible organization under section 1395mm of this title, or a PACE program under section 1395eee of this title.

(i) Option to use other payment models

(1) In general

If the Secretary determines appropriate, the Secretary may use any of the payment models described in paragraph (2) or (3) for making payments under the program rather than the payment model described in subsection (d).

(2) Partial capitation model

(A) In general

Subject to subparagraph (B), a model described in this paragraph is a partial capitation model in which an ACO is at financial risk for some, but not all, of the items and services covered under parts A and B, such as at risk for some or all physicians’ services or all items and services under part B. The Secretary may limit a partial capitation

model to ACOs that are highly integrated systems of care and to ACOs capable of bearing risk, as determined to be appropriate by the Secretary.

(B) No additional program expenditures

Payments to an ACO for items and services under this subchapter for beneficiaries for a year under the partial capitation model shall be established in a manner that does not result in spending more for such ACO for such beneficiaries than would otherwise be expended for such ACO for such beneficiaries for such year if the model were not implemented, as estimated by the Secretary.

(3) Other payment models

(A) In general

Subject to subparagraph (B), a model described in this paragraph is any payment model that the Secretary determines will improve the quality and efficiency of items and services furnished under this subchapter.

(B) No additional program expenditures

Subparagraph (B) of paragraph (2) shall apply to a payment model under subparagraph (A) in a similar manner as such subparagraph (B) applies to the payment model under paragraph (2).

(j) Involvement in private payer and other third party arrangements

The Secretary may give preference to ACOs who are participating in similar arrangements with other payers.

(k) Treatment of physician group practice demonstration

During the period beginning on March 23, 2010, and ending on the date the program is established, the Secretary may enter into an agreement with an ACO under the demonstration under section 1395cc-1 of this title, subject to re-basing and other modifications deemed appropriate by the Secretary.

(Aug. 14, 1935, ch. 531, title XVIII, § 1899, as added and amended Pub. L. 111-148, title III, § 3022, title X, § 10307, Mar. 23, 2010, 124 Stat. 395, 940.)

REFERENCES IN TEXT

Parts A, B, and C, referred to in text, are classified to sections 1395c et seq., 1395j et seq., and 1395w-21 et seq., respectively, of this title.

AMENDMENTS

2010—Subsecs. (i) to (k). Pub. L. 111-148, § 10307, added subsecs. (i) to (k).

§ 1395kkk. Independent Payment Advisory Board

(a) Establishment

There is established an independent board to be known as the “Independent Payment Advisory Board”.

(b) Purpose

It is the purpose of this section to, in accordance with the following provisions of this section, reduce the per capita rate of growth in Medicare spending—

(1) by requiring the Chief Actuary of the Centers for Medicare & Medicaid Services to

determine in each year to which this section applies (in this section referred to as “a determination year”) the projected per capita growth rate under Medicare for the second year following the determination year (in this section referred to as “an implementation year”);

(2) if the projection for the implementation year exceeds the target growth rate for that year, by requiring the Board to develop and submit during the first year following the determination year (in this section referred to as “a proposal year”) a proposal containing recommendations to reduce the Medicare per capita growth rate to the extent required by this section; and

(3) by requiring the Secretary to implement such proposals unless Congress enacts legislation pursuant to this section.

(c) Board proposals

(1) Development

(A) In general

The Board shall develop detailed and specific proposals related to the Medicare program in accordance with the succeeding provisions of this section.

(B) Advisory reports

Beginning January 15, 2014, the Board may develop and submit to Congress advisory reports on matters related to the Medicare program, regardless of whether or not the Board submitted a proposal for such year. Such a report may, for years prior to 2020, include recommendations regarding improvements to payment systems for providers of services and suppliers who are not otherwise subject to the scope of the Board’s recommendations in a proposal under this section. Any advisory report submitted under this subparagraph shall not be subject to the rules for congressional consideration under subsection (d). In any year (beginning with 2014) that the Board is not required to submit a proposal under this section, the Board shall submit to Congress an advisory report on matters related to the Medicare program.

(2) Proposals

(A) Requirements

Each proposal submitted under this section in a proposal year shall meet each of the following requirements:

(i) If the Chief Actuary of the Centers for Medicare & Medicaid Services has made a determination under paragraph (7)(A) in the determination year, the proposal shall include recommendations so that the proposal as a whole (after taking into account recommendations under clause (v)) will result in a net reduction in total Medicare program spending in the implementation year that is at least equal to the applicable savings target established under paragraph (7)(B) for such implementation year. In determining whether a proposal meets the requirement of the preceding sentence, reductions in Medicare program spending during the 3-month period immediately